REFERRAL FORM

SENIOR SUPPORT SERVICE - CPHC

Updated October 04, 2021

Please return the completed referral form by FAX: (613) 342-8992. If you have any questions please call our staff at (613) 342-3693 or 1-800-465-7646

CLIENT INFORMATION

NAME: **REFERRAL DATE:** / /

ADDRESS:

Street#/Apt# Street Name City Province Postal Code

AGE: **BIRTH DATE:** / / **GENDER:** ☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Prefer not to say

TELEPHONE NUMBER: **Home:** **Cell:**

ALTERNATE CONTACT PERSON (If applicable): **Phone:**

OHIP NUMBER:

REFERRING HEALTHCARE PROVIDER INFORMATION

NAME: **PHONE:**

☐ Family ☐ Self Referral ☐ Home & Community Care Support Services ☐ Physician / Nurse Practitioner / Physician Assist.

☐ Geriatric Mental Health Community Team ☐ Regional Care Coordinator ☐ SMILE

☐ ODSP ODSP ID#: ☐ Ontario Works ☐ Other:

PLEASE CHECK REFERRAL SERVICES REQUESTED:

☐ **Adult Day Program** ☐ **Transportation** ☐ **Meals On Wheels (hot or frozen)**

☐ **Foot Care** ☐ **Diners Club** ☐ **Home Help / Home Maintenance**

☐ **In Home Respite** ☐ **Caregiver Support / Education** ☐ **Exercise** ☐ **Fall Prevention**

☐ **Wellness Calls** ☐ **Lifeline**

☐ **Stroke Survivor & Caregiver Support Group/ Aphasia Conversation / Living with Stroke Education**

☐ **Creating Connections Virtual Program** ☐ **Seniors' Centre Without Walls (SCWW) Phone Program**

ANY FURTHER COMMENTS REGARDING THIS REFERRAL